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ISSN 1180-4327

Legislative Assembly of Ontario

Second Session, 41st Parliament

Assemblée législative de l'Ontario

Deuxième session, 41e législature

Official Report of Debates (Hansard)

Wednesday 26 October 2016

Journal des débats (Hansard)

Mercredi 26 octobre 2016

Standing Committee on Public Accounts

2015 Annual Report, Auditor General

Comité permanent des comptes publics

Rapport annuel 2015, vérificatrice générale

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
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Publié par l'Assemblée législative de l'Ontario

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 26 October 2016

Mercredi 26 octobre 2016

The committee met at 1231 in room 151, following a closed session.

2015 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.09, Long-Term Care Home Quality Inspection Program.

The Chair (Mr. Ernie Hardeman): I call the meeting of the public accounts committee to order. We're here this afternoon to have a presentation on Long-Term-Care Home Quality Inspection Program, section 3.09 of the 2015 annual report of the Office of the Auditor General. We have with us ministry people who we can question. We will have a 20-minute presentation, collectively, for the deputants who are here. We will then have questions and comments by the caucuses in rotation, starting with the official opposition, for 20 minutes each. When we make one round of that, we will then have whatever time is left to get us to 2:45, and we will divide that equally among the three caucuses and make a second round.

We'd also like to point out and ask for the co-operation of the delegates, to make sure that when it becomes your turn to speak that you introduce yourself, to make sure that Hansard gets the right person, because I'm sure every one of you will not want to have to take the responsibility for what your neighbour said.

Thank you very much for being here. We'll start, Deputy, with your presentation.

Dr. Bob Bell: Thanks for the opportunity to be here.

We'd like to say thank you for the opportunity to address the Standing Committee on Public Accounts with respect to the Auditor General of Ontario's report on the Long-Term Care Home Quality Inspection Program.

With me is Sharon Lee Smith, associate deputy minister for policy and transformation; to her right, Brian Pollard, who is currently the acting ADM of the long-term-care homes division; and Karen Simpson, director of the long-term-care inspections branch.

We'd obviously also like to thank the Auditor General of Ontario, Bonnie Lysyk, for her report on the long-term-care homes inspection program. We appreciate her advice on how we should strengthen the inspection program in Ontario.

Before beginning, we want to start by acknowledging that yesterday we all heard the distressing news from the OPP about charges laid with respect to eight deaths in two long-term-care homes in Woodstock and London. We can confirm that the ministry has been co-operating with the police in this matter. However, I'm sure you can appreciate and understand that while we're extremely concerned for families, as all Ontarians are, since this relates to an ongoing police investigation, the police should remain the primary source of any information on this matter at this time, and it would be inappropriate for me or my colleagues to comment. We obviously want to assure all Ontarians that the safety and security of Ontario's long-term-care residents is of utmost concern to us. But, again, we need to recognize there is an ongoing police investigation and it would not be appropriate to comment further at this time.

I'd like to turn now to some background information on the long-term-care sector and our inspection process, to be considered as context for the work under way on the auditor's recommendations.

Over 78,000 Ontarians call the province's 628 long-term-care facilities home. These homes range in size from fewer than 30 to over 400 beds and are located in cities, towns and municipalities across the province.

The vast majority of residents are considered long-stay; a smaller number—less than 2,000—are classified as short-stay, and are using long-term-care facilities either for a period of convalescence as they transition from hospital to home, or for a period of respite.

The Long-Term Care Homes Act, 2007, and its associated Ontario regulation 79/10 reflect the fundamental principle that a long-term-care home is the primary home of its residents and is to be operated so that it is a place where residents may live with dignity.

Based on a jurisdictional review, we are confident that Ontario's Long-Term Care Homes Act is comprehensive and forward-thinking, and is leading jurisdictionally in Canada and internationally. We work to continually transform the inspection process. The auditor's recommendations are helping us to direct resources to where they are needed most.

I'll now provide background on the long-term-care homes inspection program. The Long-Term Care Homes Act and regulation set out the ministry's key requirements with respect to residents' rights and protections, service requirements, accountability, system management, inspection and enforcement. We continuously

inspect long-term-care homes as part of a comprehensive program called the Long-Term Care Home Quality Inspection Program, or LQIP. We've been doing this since the implementation of the legislation in 2010.

The program receives an average of 3,300 complaints per year, which translate to about 275 per month. Complaint inspections respond to complaints received from residents, families or staff. Approximately 72% of complaints are triaged for either inspection or inquiry.

The program also receives an average of 13,800 critical incident reports per year, or about 1,150 per month. Critical incident reports respond to incidents that are required to be reported by long-term-care home operators, and approximately 42% of these are triaged for inspection or inquiry.

In 2015, we completed 2,360 inspections, of which 764 were complaint-driven and 615 were critical incident inspections. The balance is resident quality inspections or follow-ups.

In June 2013, the government announced that every long-term-care home would receive a comprehensive annual inspection called the resident quality inspection, or RQI, every year. We're pleased that for the past two consecutive years—2014 and 2015—we've met this annual commitment. This year, we're on target to meet the commitment for a third year. We have 189 inspector positions, with a dedicated team of management and staff supports, to help facilitate inspections in every region of the province.

Reporting on the audit's recommendations: The ministry has taken concrete steps to address the recommendations contained in the report. The Auditor General's report and recommendations for the long-term-care quality improvement program centre around four major themes: timeliness of inspections, safety assurance, improved enforcement and overall quality improvement. We feel that we're now over 60% of the way to fulfilling the recommendations of the report. I hope that we will have reached full implementation in the next six months.

On the theme of timeliness, the Auditor General recommended that the inspection program take action to:

(1) Significantly improve the timeliness of inspecting complaints and critical incidents.

(2) Better track, prioritize and monitor the handling of complaints and critical incidents.

(3) Put the safety of residents first by focusing on high-risk areas.

(4) Establish clear policy guidelines for inspectors to use in determining an appropriate time frame for homes to comply with orders.

(5) Establishing a formal target for conducting follow-up inspections on orders.

(6) Ensure residents' concerns are addressed equitably across the province by periodically reviewing and addressing inspectors' workloads and efficiencies across the regions.

A number of the AG's recommendations focused on the need for the ministry to review the inspection program to ensure that it had appropriate resources to support the program. To do this, the ministry conducted an operational review which called for additional resources to be added. These resources have been approved and are either in place or are in the process of recruitment.

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The Auditor General also identified at the time of the audit that a total of 2,800 complaint and critical incident intakes were awaiting inspection. These are all complete except for a small number scheduled to be completed and recorded before the end of this calendar year.

We continue to manage a significant volume of complaints and critical incidents requiring inspection. We have therefore undertaken a targeting process to realign resources to inspect important issues more quickly.

We know that the number of critical incidents reported is increasing, and we consider this to be important for quality improvement since this is a step taken by operators to improve quality within their programs and report concerns. Analysis of these reported incidents supports the development of quality programs and appropriate policy options in the inspectorate. For example, we have been targeting more ministry funding and programming in the area of complex behaviours arising out of conditions like dementia, with enhancement and investment of resources to programs like Behavioural Supports Ontario.

When we receive information from complaints or critical incidents, we assess and triage each one received. We identify a risk level to support our inspection program so that inspections can be scheduled in accordance with that risk level. As a result of the Auditor General's recommendations, benchmark timelines for our responses have been established for levels 3, 3+ or 4, with benchmarks for level 4 being immediately, within 24 to 48 hours; level 3+ within 30 days; and level 3 within 60 days.

Information technology improvements are being implemented to track the progress of inspections against these benchmarks. This will be one of the key performance indicators in management reports going forward and will be used by the program to monitor and improve performance, along with time from inspection to finalization and posting of inspection reports.

We know, of course, there will always be intakes pending inspection. Our target for impending inspection intakes is approximately 1,000, based on our current rate of intakes. We know we have more work and prioritization to do to get to the right level to achieve our target. Some of this work we'll explain to you.

We have revised criteria for the program's centralized intake, assessment and triage team in place to assess all critical incidents and complaints to determine potential risks and prioritization of inquiries and inspections.

The program has developed greater provincial consistency in management and delivery of the inspection program—specifically, the application of consistent criteria to assess the level of operational risk of long-term-care homes and inform inspection prioritization; increased consistency in setting compliance due dates for similar

episodes of non-compliance; and more formal targets for timeliness of follow-up inspections.

We have tracking mechanisms and random as well as scheduled audits of internal processes in development, with implementation to follow.

All ministry inspections are prioritized on a daily basis depending on the risk of harm presented to patients, with a need to continually assess and reprioritize inspections to ensure that issues that present the highest level of harm or risk of harm to residents are addressed in a timely fashion.

We have also initiated an IT update that enumerates intakes outstanding by risk level, priority and date. The first phase of this reporting project provides the program with the ability to plan and monitor inspections and evaluate the timeliness of intakes. The first phase of this IT program went live in August 2016, with the second phase now in progress; it will form part of our monthly management reporting by January 2017.

The inspection program monitors its progress in completing inspections and addressing the complaints and critical incidents needing inspection. Importantly, thus far in 2016, the program has inspected an average of 566 intakes per month. This means that we are now inspecting 59% more intakes per month than we were in December 2015 at the time of the Auditor General's report.

Contact with complainants is important, and the current policy requires inspectors to contact the complainant after the inspection to let them know the results of an inspection. This policy is being reinforced through further training of inspectors and other communication. As well, the inspector needs to document the content and date of their contact with the complainant.

Focusing on risk, as suggested by the Auditor General, a new risk-focused approach to resident quality inspections, RQIs, was introduced in August 2016. All long-term-care homes continue to be subject to an RQI annually in keeping with the government's commitment. The intensity of the RQI is informed by the home's compliance history and risk level, now that we have the third year of information about homes. We believe that all of the improvements completed and under way will allow us to get to the right level of pending inspection intakes by early 2017 through this process of realigning resources, as suggested by the Auditor General, based on a risk assessment and aligning the inspection process with risks considered in the homes.

Approximately 80% of homes are considered substantially compliant in their overall operations and provision of resident care; that is, they're low-risk homes with good compliance records. System checks and balances are ensured. Each year, one third of substantially compliant homes will receive an intensive risk-focused RQI.

Some have criticized this risk-based strategy; however, it was a key recommendation in the Auditor General's report. This approach enables the ministry to invest many more resources in homes with moderate to high-risk profiles, as well as increasing our rate of inspection for the pending intakes related to complaints and critical incident reports that we talked about earlier.

On the theme of safety assurance, the Auditor General recommended the inspection program should take action to mitigate the risk of fire in LTC homes. This recommendation is 100% complete. The Office of the Fire Marshal and of course the local fire departments have jurisdiction for the inspection of fire safety measures. The ministry has engaged the fire marshal's office and established a memorandum of understanding, which was completed in June of this year, allowing for an exchange of information between the LTC home inspection program and the Ontario fire marshal on issues related to fire safety risk.

On the theme of improved enforcement, the report recommended the inspection program take action to strengthen enforcement processes to ensure that long-term-care homes are not repeatedly in non-compliance, they're held accountable for their performance, inspection results are communicated in a timely fashion, and the public is provided with better information for decision-making on homes.

We've reviewed options to strengthen the existing enforcement framework and the feasibility of adding additional enforcement tools. After an interjurisdictional scan and examination of best practices, we're applying the features of a responsive regulatory model and developing a comprehensive enforcement policy and procedure. It's already helping to support consistency in practice by inspectors and senior managers across the province.

Initial training was provided to inspection staff on this responsive regulatory model in June of this year. Significant progress has already been made in addressing repeat non-compliance by licensees. For example, the number of director referrals has increased from a total of eight between 2011 and 2014, to 35 in 2015, to 58 year-to-date in calendar 2016. Director referrals are a mechanism set out in the act that allows inspectors to refer matters to the director where they believe a higher level of action or sanction is warranted. As a result of the director referrals, focused and intensive discussions have occurred with licensees who have been noted to be repeatedly in non-compliance, leading to better addressing their non-compliance and improving resident care.

We've worked to improve consultation and conversation with our LHINs. Representatives from the LHINs and the ministry are now working on a framework to ensure a cross-reporting process being implemented. That will allow the local health integration networks and the ministry to share long-term-care inspection information.

In communicating our results, the ministry has established benchmarks for completion of inspection reports after on-site inspections, as well as reporting inspection results to the long-term-care licensees and the public. The timely completion and posting are now key performance indicators of the LQIP quality assurance program.

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Business processes and procedures were put in place in February this year to monitor the posting and timeli-

ness of inspection reports to the public reporting website. Better information is available about inspection results with current publication of all inspection reports and orders on the public website, sorted by individual homes. Further work is under way with Health Quality Ontario to consolidate, centralize and standardize further reporting.

On the theme of overall quality improvement, the report recommended the inspection program take action to ensure the identification of KPIs and establishment of reasonable targets. With consultation, this work is over 40% complete.

Enabled by the inspectors' quality solution inspection application, a wide variety of performance-tracking measures and reports are in place, such as complaint and critical incident intake tracking, inspection volumes and annual RQI and complaint inspection completion. Further KPIs were finalized in May this year as part of a balanced scorecard approach to program reporting, which will begin later this year.

As we continue to analyze the data and the KPIs from the program to further identify opportunities for initiatives to support staff and residents, we're simultaneously developing a comprehensive dementia strategy to address the needs of Ontarians with dementia.

Building on the work of the advanced stage dementia working group and recent discussions with the Geriatric and Long-Term Care Review Committee, the ministry is addressing the complex issue of responsive behaviours in long-term-care homes that can lead to resident-to-resident or resident-to-staff abuse by creating a time-limited clinical consultation working group to provide actionable feedback to the ministry with discussions beginning in November this year.

In closing, I trust this overview has provided you with confidence that the Long-Term Care Home Quality Inspection Program has acted on all of the Auditor General's recommendations as part of our quality improvement journey.

We must continue to transform the long-term-care sector, but we cannot lose sight of the most important goal, which is our responsibility to help keep our residents healthy and safe, allowing them to live in a residence that supports their dignity.

The Long-Term Care Home Quality Inspection Program is one of the ways the ministry is demonstrating a real commitment and achieving these goals. Thank you, Mr. Hardeman.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Obviously the word count is just a little shy.

Dr. Bob Bell: Just a little shy.

The Chair (Mr. Ernie Hardeman): There were three extra words, but with that, we will go to the official opposition to start the questions and comments.

Mr. Bill Walker: Welcome. Thank you, everyone, for attending.

Dr. Bell, would it be possible to get a copy of what you just shared with us in writing? That would be helpful because I may ask you some questions and I couldn't, of course, maintain all of it.

I think what we heard in the Auditor General's report this morning that was most concerning for me—and you may be addressing some, but I'll get into a few specifics—is really the accountability and what's happening when we realize we're in non-compliance, that someone isn't reporting. A number of things came up in regard to 100 inspectors being put in, but did we really have any analysis of where they were required in regard to the actual incidents that are happening across the province? I think what I heard this morning is we kind of just allotted them equally in the various regions, but if there's a really needy region, we may have needed to do that. So have you done any work to reassess and evaluate and to say we're deploying those now based on need as opposed to just the first kick?

Dr. Bob Bell: Thanks very much, Mr. Walker. It is Bob Bell speaking.

I'm going to start off and then turn to my colleague, Karen Simpson, who is in charge of the program.

Yes, we do have regional office service area organizations that actually have their own regional wait times being reviewed. Their workload, as well as their KPI, is based on wait times. The number of reports completed per inspector posting those reports are all determined on a regional basis.

Perhaps I could turn to Karen to describe how we actually maintain measurement of those KPIs and look at allocation of resources on a regional basis.

Mme France Gélinas: Remind me what KPI is.

Dr. Bob Bell: Key performance indicators.

Ms. Karen Simpson: Hello, everybody. Karen Simpson, director, long-term-care inspections branch with the Ministry of Health and Long-Term Care. Thank you very much, Mr. Walker, for your question.

What we have, as you may be aware, are five service area offices across the province who are dealing with issues in their local LHIN areas. What we've put in place is a system whereby as needs for inspection increase, we deploy inspectors from other parts of the province to come in and support those various areas. We do have plans as well, as we move forward and as inspectors move in and out of the program, to redeploy more permanently to those areas of the province where we may need resources.

A very concrete example of this is that in about March or April of this year, we deployed teams from the whole province to Toronto to help us address where we had a critical backlog. We completed over 1,000 intakes at that point in time. Teams from Sudbury, Ottawa, London and Hamilton all came to Toronto and worked with our Toronto team—to support them—who were having some difficulties initially recruiting.

It's very much a provincial program. When we have critical issues, as we do from time to time, we do redirect resources appropriately and support those service area offices to address the needs.

Mr. Bill Walker: When you're doing that, if you are finding there is a more long-term concern, are they physically being redeployed to those regions—again, I'm

concerned that you're going to be sending people all over the province at a fairly significant cost—as opposed to, if there's an area of high incidence, are you totally, permanently redeploying and then assessing, obviously, in case it does change again?

Ms. Karen Simpson: Yes. We actually have a plan in place to look at that as we're moving forward over the next year. Obviously, we need to look at it as people move out of the program, because you don't want to disrupt individuals. But certainly, in areas of the province where we know we have a higher need, we are not only deploying—we have an Oshawa office that supports our Ottawa office. It sounds a little strange, but it is part of our Ottawa office. Oshawa is able to help support our Toronto folks, because they're sort of on the border. Hamilton is also able to help support into the west side of Toronto. So we are moving people in that way to properly support the program, and have a longer-term plan that, as resource needs shift, we shift resources to meet that.

Dr. Bob Bell: Part of the issue here is that these folks, once they become expert inspectors, are also expert in quality improvement within long-term-care homes, so they're very valuable recruits for the industry itself. So we do see a fair amount of turnover, which we think is good, because it brings more quality experts into the long-term-care community.

Mr. Bill Walker: On a related note, are you putting any accountability measures in? For example, I'm going to quote from the report: "40% of high-risk complaints and critical incidents that should have been inspected immediately"—I'm assuming "immediately" means within a 24-hour period, and if that's not correct, please correct me—"took longer than three days."

Sending someone in is great. Saying we've addressed it is great. But are you really, truly, getting it down to the 24, and what happens if they don't?

The other one is that 25% of these cases took between one and nine months for inspection.

Again, saying "we've redeployed" works for me, but I want to know that you're actually tracking that we are getting back to—what we should be expecting is compliance at 100%.

Dr. Bob Bell: Let me start off again, and then I'll probably turn to Karen.

Probably the most important number I spoke to during the report was the fact that, based on the Auditor General's advice and our own desire to have a more risk-based system, we've increased throughput of inspections by 60%.

As you can imagine, this is a rate issue. We have an increasing number of complaints coming in. We encourage that. We want to know, from homes, when there are risks to clients, to residents. We've increased our throughput of complaints substantially, especially in triaging more significant complaints.

Maybe I could turn to Karen for our current performance around what we call level 4 complaints, those that have a risk of real harm to residents and that we think should be inspected within 24 to 48 hours.

Ms. Karen Simpson: On the level 4s, we don't have a lot of those, which is good news. They are easy to track as well, because we don't have a lot.

The direction across our program is within the 24 to 48 hours. Sometimes it takes us a little while to get there. In the north, for example, we do have to send inspectors where it sometimes may take up to a day to even get there. So the direction is that within 24 to 48 hours, we have an inspector on the ground to address those issues, and we're meeting those targets.

Those are our most critical issues, and we have resources deployed to address them when they come up.

Dr. Bob Bell: The other part of your question, Mr. Walker, that I think I heard originally was, what happens if a home is inspected and found to be non-compliant and stays non-compliant? Was that it?

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Mr. Bill Walker: Yes. Certainly, in our overview this morning, a lot of discussion was around there not being a follow-up—sorry, there may have been a follow-up, but nothing really changed; right? To say, "I've gone and inspected you a second time," does nothing, in my mind, for the patients' safety and the families' concerns. What I wanted is to make sure there was some language that there are repercussions, that there are some accountability measures that you've implemented to ensure that not only am I walking back into the facility to say, "Yes, I'm here again," but, more importantly, what is actionable.

Dr. Bob Bell: This is crucial for us. I totally agree with you. This is something that our team really spent some time thinking through; it looked at international jurisdictions as to best practice and has broadened the place of the responsive regulatory model that I mentioned to you, which escalates problems in a hierarchical fashion. If homes continue to be non-compliant, there are real consequences.

Perhaps I could ask Karen to describe what that responsive approach is.

Ms. Karen Simpson: Yes, absolutely. We've done a lot of data analysis as well, because what we do know is there are a very small percentage of homes that actually have that repeat and recurring issue. In those homes where we do have that repeat and recurring issue, we have to address those concerns, because you are absolutely right that those are where issues may be for residents in those homes.

What we've done, as a first step, is we've looked at how we can better use the current tools available to us within the legislative framework. We have issued mandatory management orders, which we had never issued before. We have increased the number of director's referrals. I know personally that I'm very busy in that area. We've talked to licensees.

We expect compliance and we follow up to ensure. We're actually seeing significant positive results and people getting back into compliance as a result of that. We've also updated our policies, so that inspectors are consistent in their approach.

Saying that, that's what we've done within the current legislative framework, using the tools that we have

available to us more effectively. However, we've also identified that there are some additional tools or policy options that we need to consider going forward. In fact, we did meet with some of the key stakeholders this morning just to talk about that suite of enforcement options that we could be considering, which includes talking to licensees and talking to resident and family councils about the work that they're doing to address those non-compliances, because they are the critical stakeholders who need to be informed and need to be aware. Up to now, they haven't always been as aware.

That was very well received. There are other legislative and regulatory options that we're considering and that we are planning to bring forward in the near future to help strengthen the tools available to us to address those homes with repeat non-compliance, which again, I just want to reinforce, are a small percentage of the homes in our system. Most of our homes are doing a really good job of caring for their residents.

Mr. Bill Walker: Thank you. In figure 4, there was a—did you use the term "director's referral"?

Ms. Karen Simpson: Yes.

Mr. Bill Walker: In figure 4, which we looked at this morning, from 2012, 2013 and 2014, there was a director's order—only one in 2012; zero in 2013-14. Is this director's referral another added element in there, or is that the equivalent?

Again, I don't know the industry that well. I'm just starting to learn a lot of this long-term-care stuff. But it would seem to me, when we hear anecdotally out in the community of the issues and challenges that we have, there wouldn't be more than one—and, in many cases, zero—director's order in a year across 630 homes.

Dr. Bob Bell: The number in this current calendar year to date is 58.

Mr. Bill Walker: Fifty-eight?

Ms. Karen Simpson: For director's referrals.

Mr. Bill Walker: Okay. Can you just provide clarification? Is that different from a director's order?

Ms. Karen Simpson: A director's referral is provided for in the legislation. That allows the inspector to refer to the director where they believe that there needs to be some other action or sanction applied that is beyond the scope of the inspector, which could include, as I've indicated, the meetings with the licensees, and we invite the LHINs to those. So that's a director's referral.

As a result of the director's referral, there could be other actions or sanctions that the director takes. One of those could be a director's order; another could be a mandatory management order, which we've done in two situations in the province in the last seven or eight months. It could also be other steps—a cease of admissions, for example, which we've also undertaken. So a director's order is just one piece of the toolkit. It's just one element.

Mr. Bill Walker: I'm assuming a director's order is a fairly significant order.

Ms. Karen Simpson: Yes.

Dr. Bob Bell: It allows for a hierarchical response. To stop admissions, stop payments or revoke licences are all steps that can be considered.

Mr. Bill Walker: Sure. Could you just give me an example of an order and what type of a time frame you would give for a director's order to be made compliant?

Ms. Karen Simpson: An example of a director's order? Well, I can give you the mandatory management order as a good example. When we issue that, we specify within the order, the specific time frame: in one case, two weeks to get me the name of a management company that would then be submitted to the director for approval; two weeks from the date of approval to actually get us a draft management contract; and then, subsequent to our approval, the company within that home within X period of time. That forms the basis of one of those specific orders that actually was issued provincially.

Mr. Bill Walker: And if someone didn't meet one of those two-week deadlines that you've used as an example, what happens?

Ms. Karen Simpson: If somebody doesn't meet that deadline, we have other options in the legislation. We do have the option to revoke the licence and, subsequently, close the home. Obviously, that would be the last step that we would want to take because of the impact to residents, but there are other options available to us should the licensee not comply. To date, they are complying.

Mr. Bill Walker: Thank you. Again in the report I'm referring to: "Sixty percent of our sample of medium-risk cases"—and that is the majority of cases that typically are found—"that should have been inspected within 30 days took an average of 62 days." So, again, not a great number that we're looking at. What I want to focus on a little bit is, though, was the 30-day original expectation realistic?

Dr. Bob Bell: We think it is, and that continues to be our expectation for the three-plus types of complaints. What we've tried to do, Mr. Walker, is to realign our resources so that we can focus more on this risk-based approach. By increasing our rate of inspection by 60%, we think that we're going to be able to get back to that 30-day benchmark. Is that fair, Karen?

Ms. Karen Simpson: Yes.

Mr. Bill Walker: How does that benchmark compare with leading sectors, whether in Canada or worldwide?

Ms. Karen Simpson: On that issue, we actually have one of the most robust and comprehensive pieces of legislation and inspection programs across Canada and, dare I say, internationally. The United States is probably the closest, from an intensity perspective, to Canada or to Ontario. It's hard to compare, because our legislation and our requirements are very comprehensive and very robust. I think we have a leading program that is leading the way on inspection to ensure the safety and security of residents.

Mr. Bill Walker: Okay. Thank you.

We heard a little bit again this morning that you had to bring in 100 new inspectors, so obviously there was a lag in time to get trained. Can you give me a sense of your

numbers of what I would consider your very experienced inspectors right down to kind of the beginner?

Ms. Karen Simpson: I don't have the specific facts in front of me. What I would suggest is that over the last two years we have brought in a lot of new inspectors, and we do have a 13% to 14% turnover annually. I would say that we probably have 60% to 70% who have been hired within the last couple of years, and 30% to 40% would be experienced, but I can get you accurate numbers after.

Mr. Bill Walker: I would appreciate that. Thank you very much.

Switching gears a little bit, one of the recommendations that came out from the Auditor General this morning was in regard to the local health integration networks. Again, they have information, but are they really utilizing it? Can you give me a kind of overview of the protocol of how they are integrating with you to make sure that we're all going in the same direction and that they actually have the ability to implement what we need them to be doing?

Dr. Bob Bell: Let me just start off by speaking to the importance of that. Of course, the local health integration networks are increasingly, pending the passage of Bill 41, more responsible for integration of services, so it is crucial that they are aware of the quality of care being provided within the long-term-care sector. I know we've made some very concrete steps toward engaging them in a discussion of the long-term-care quality inspection process outcomes, and I know we've got some concrete steps that we take. Karen, would you mind describing them?

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Ms. Karen Simpson: No, absolutely. When we have a home that is in a situation where we have a director's referral, we have a protocol whereby we are engaging with the LHIN locally prior to meeting with the licensee to talk about the issues that we've identified in that home, and talk about anything that the LHIN may be seeing on their side—any concerns that they may have.

What we do is set up a meeting with the licensee. The LHIN is invited to that so that they can be a part of that discussion and then part of that quality improvement journey going forward, because they obviously have a real commitment and interest in well-being and making sure that those homes succeed. So we involve them at that level.

The other level that we're working on right now is a mechanism to share our data more robustly with LHINs, and LHINs share data back with us, and that's the cross-reporting process that the deputy spoke to. The plan is to move that forward. We have initial steps on that to move that forward in early to mid-2017.

Mr. Bill Walker: Thank you. Again, the information this morning shared that, "The ministry does not provide clear guidance" on how much time long-term-care homes should be given "to comply with orders to correct issues identified during inspections." Again, just give me a quick summary of—what I'm really getting at, and I hope you're seeing, is that accountability. There has to be a specified time. There has to be an expectation that there's action, not just review.

Dr. Bob Bell: One of the real lessons that we took away from the Auditor General's recommendations was the importance of having a greater response to problems that were identified by inspectors in the home, and to ensure, with follow-up, that the compliance with those changes was being achieved.

Again, Karen, can I just ask you to describe how we're currently responding at the director level?

Ms. Karen Simpson: Yes. We've spent a lot of time over the past six months updating our policies and procedures that govern our inspection program. We have training scheduled for December to roll out all of those policy and procedural changes in December. Some, we've already rolled out, but this is the bulk of them.

This includes work that we've done on compliance timelines. What we've done is we've actually looked at the type of order in the key care area and at what compliance timeline should be in there. It's a benchmark, because in different situations with different homes, you may have to move within that. For example, with a 300-bed home, if you're looking at education, it's going to take longer for that home to educate all those 300 than it would, say, a 60-bed home. So there would be a difference in compliance timelines.

However, we've developed guidance and benchmarks for our inspectors. That policy work, the education on that, is already scheduled and is happening in early December.

Mr. Bill Walker: Maybe an expansion of that—

The Chair (Mr. Ernie Hardeman): Thank you very much. I think we'll stop right there and turn the floor over to the third party: Ms. Gélinas.

Mme France Gélinas: Welcome to public accounts. My first series of questions will have to do with the changes that you have done from quality inspection to different intensity. Do you think that we now have it right, that going with the 20% that you have found to be non-compliant, plus a third of the 80% that have been found to be in compliance, gives us the right resources to handle the critical-incident complaints, the follow-up and everything else you have to do? Do we have it right now?

Dr. Bob Bell: I'm not sure that we have it right. But to give you a sense of scale, the RQI that was previously undertaken annually for every one of the 600-plus homes in the province engaged, typically, three inspectors for five to 10 days, depending on the issues that they were discovering.

We're continuing to have RQIs for every home, as we mentioned, with a third of them going back to this in-depth inspection on a random basis every year. But that obviously allows us to take inspection resources and apply them to a more risk-based approach.

Do we have it right? I think the key performance indicators that we're tracking now, with time to inspection of a 3, a 3+ and a 4, are the kinds of metrics that we're looking at, along with the resources available on a regional basis. This is all over the nine months that we've

been in action since the Auditor General's report, responding to that. We probably don't have it quite right. I have no doubt that we'll be making further modifications, but we think it's certainly a step in the right direction, as demonstrated by the 60% increase in throughput that we've been able to demonstrate.

Mme France Gélinas: Okay.

Dr. Bob Bell: That 60% increase, I should say—we only changed our approach with reallocation of resources in August of this year, so that's pretty soon after the change.

Mme France Gélinas: Okay. Do you track right now the backlog of critical incidents, of complaints, of comprehensive as well as follow-up inspections? Where is this tracked and can you share that with us? Is this available to anybody but you?

Dr. Bob Bell: We do track it. I think that it's probably an internal management tracking system.

I'm not sure if I can ask you, Karen, whether you have that information in your hand?

Ms. Karen Simpson: I do.

Dr. Bob Bell: I thought you might.

Ms. Karen Simpson: We do have that information monthly. As the deputy indicated in his speaking remarks, our plan to move forward with the risk-based approach to the RQIs will allow us to get more resources to tackle the backlog. We estimate—I think the deputy may have already said this—that we should have on average about 1,000 waiting, because we have about 700 a month coming in the door that require inspection. These are at the 3, 3+, 4 levels. We have about 700 a month that require inspection in that area. So about 1,000—because some would be 60 days; some would be 30; some are immediate—is what we think is a reasonable number that should be there waiting.

Right now, we have approximately 3,700 waiting to be inspected so we know that we have more work to do. We're really confident that, given the plan that we have in place, into 2017 we will get to the level of pending intakes that we need to be at, and we have a concrete plan to get there.

Mme France Gélinas: Could you break that down? Of the 3,700, how many of those are critical incidents and by level? How many of them are complaints? How many of them are follow-up inspections? And you put all of this in the 3,700?

Ms. Karen Simpson: Yes.

Mme France Gélinas: Does anything else go in there, or just those three?

Ms. Karen Simpson: Within that are the 3s, 3-pluses and 4s. Approximately 650 are complaints. The balance would be critical incidents.

Mme France Gélinas: Okay. You went too fast: 650 are complaints?

Ms. Karen Simpson: Approximately.

Mme France Gélinas: Okay. So that leaves 3,050 as critical incidents.

Ms. Karen Simpson: About 3,000 would be critical incidents. Actually, 786, if you want the exact number, and 2,909 are critical incidents. We have 29 others which are issues related to CCAC placement, so they're not actually long-term care; they may be related to admission and discharge issues.

Dr. Bob Bell: Of those, to give you a sense of the scale, five are critical incidents. These have the inspectors in the home within 24 to 48 hours. The inspection may not yet be complete or the posting of the inspection may not have been completed yet, but the inspector is certainly in the home assessing risk immediately.

Mme France Gélinas: Wow. It's kind of a big number. I didn't expect it to be that big. But you feel confident—that was my first question to the deputy—that with the redeployment of your resources, you will be able to bring that down to 1,000, with very few of them being a level 4.

Dr. Bob Bell: We're comfortable that level 4s get immediate addressing of the issue, as we've described. I think it's important for the committee to recognize that part of the principle of quality improvement is really the encouragement of reporting of critical incidents. A critical incident that a home would report is a resident, for example, who may be missing for three hours. That's a critical incident, obviously. These numbers of complaints—we're encouraging operators to increase their reporting of these so that we can both do the inspection and, more importantly, understand the experience the residents are having. So managers and their staff are encouraged to report these.

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We think that the reallocation—if you think about the presence of three inspectors in an RQI for 10 days changing to the current low-risk RQI that might take two inspectors five days, we're substantially reallocating our resources. We thought that it was important to get two years of data as to who were the compliant and non-compliant operators in the system. We have that now and we will continue to check them, but we have substantially realigned our resources.

Going back to your earlier prescient question, have we got it right? We will continue to track and make reallocations of resources as appropriate. We are committed to getting down to the level of about 1,000 in the queue, either waiting for inspections to start, in the process of inspection—remember, there are a lot of these that are in the process of inspection—or waiting for the report to be completed and posted.

Because of these numbers being waiting, it doesn't mean that they're waiting for an inspector to arrive. They could very well be in the process of inspection.

Ms. Sharon Lee Smith: My name is Sharon Lee Smith. I'm the associate deputy minister for policy and transformation.

Madame Gélinas, one thing that the Auditor General's report was very helpful for us was a recommendation around increasing our management reporting structure and supports to the field for data and IT solutions, to be able to have at the ready supports for the inspectors in the field to understand where the numbers are going and the

types of incidents that are being inspected. We have provided more supports internally for the IT that's needed in the management and administrative supports.

The inspectors are out in the field, but they need back-office support. They need supervisors, managers and administrators to be a part of the team to complete the findings and the knowledge transfer about what we're learning.

We're actually quite excited about that part of our business, and we've internally allocated 14 additional staff for this type of work from our operational review.

Mme France Gélinas: Okay. Coming back to the different types of inspections that you do, whether critical incidents or complaints: On the complaints side, do you accept complaints from people who are not yet in a long-term-care home but are being forced to go into a long-term-care home that is not their choice? Are those acceptable complaints, and how would you handle that?

Dr. Bob Bell: We have a category of "other." In terms of forcing people to go into a long-term-care home, I'm not sure if we've had that as a complaint.

Mme France Gélinas: They will start coming. If you tell me that you will accept those, they will come by the truckload from my riding.

Ms. Karen Simpson: I'll just speak to that briefly. We have had situations where we've had concerns coming from families around an individual who is feeling as though they are not getting their first choice of a long-term-care home. They're being encouraged very strongly to take a home that is not their first choice but may have a longer wait-list, for example.

As the deputy said, that falls into our "other" category, because we also have some jurisdiction in the inspection program over CCACs and the placement process provincially. When that happens, we work with the CCAC to understand what the issues are from the complainant's perspective and resolve them. We have given direction to CCACs on occasion where they may need to actually change their processes or policies to ensure alignment with the legislation.

We have dealt with a number of those. Again, there aren't a lot, but we do deal with them on occasion.

Dr. Bob Bell: In addition to the quality improvement process, we think that one of the reasons why complaints from residents and from family members have increased is that part of the RQI, part of the routine inspection process, is to ensure that the complaints line is prominently posted within the home for residents and families. That's part of the inspection process, so we think that's probably increased a number of responses from families and residents over the last couple of years.

Mme France Gélinas: I have it in my office also, in our waiting room. You have given direction to the CCAC before, because I get lots of complaints about that. People don't feel comfortable calling the complaint line, but now I understand that they could, where the CCAC interprets the law that once you're in a home that was not your first choice, you are now in a safe environment and therefore it's no longer a priority to go to the home of your choice—which in my CCAC and my LHINs means that you will die there because the chances of coming off of their 1A list is zero.

Have other CCACs handled the transfer into a home that is not your first choice where you keep your designation as a level 1 so that you are a priority to go into the home of your choice, and then the next bed available you do musical chairs?

Dr. Bob Bell: I think that's a pretty rare circumstance, to be straightforward, but I think it has occurred. Is that fair, Karen?

Ms. Karen Simpson: The legislation sets out the priority system for managing the wait-list for long-term-care homes in the province. You're right that when somebody moves from, say, the community or hospital environment into a long-term-care home and selects the home that's not their first choice, they do maintain their status waiting for the home of their first choice. But if they were crisis going in, they will no longer fit the crisis category based on the legislation. It will take longer than it would have if they were in a crisis.

So you're right. However, the legislation does set up a priority system and does need to manage those real priorities that are out there in the community and the hospital, who desperately need a long-term-care placement and so would then get a level-1 crisis placement.

Mme France Gélinas: If you're crisis in the community, you take first bed, no matter where it is? In my neck of the woods, it's 100 kilometres away from where you live. You accept first bed. There's a nursing home walking distance from where you've spent your entire life, but there is no way to bring you back there.

Dr. Bob Bell: My understanding is that one of the things we strive to do is to try and reunite families that are separated as you've described. I'm not sure how well or how often that is a feature of transfers. Karen, do you know?

Ms. Karen Simpson: I understand the issue that you're raising, Madame Gélinas, and I do understand as well that in rural and other areas of the province, it's a very difficult issue.

Access to long-term care is still a consent-based system. You have to consent to going into that long-term-care home and you are able to choose where you go. If you do not want to go to a specific home, even if you're a crisis 1, you have the right to say no and wait.

Mme France Gélinas: But then they say you will go to the bottom of the list for the next three months.

Ms. Karen Simpson: If that's the case, then maybe somebody needs to call us.

Mme France Gélinas: Somebody needs to call you?

Ms. Karen Simpson: Yes.

Mme France Gélinas: Hansard, you got that well? I just wanted to make sure. Okay, thank you.

We have this backlog of complaints. Do we keep track of backlogs for follow-up inspections?

Dr. Bob Bell: Karen?

Ms. Karen Simpson: Yes. For follow-up inspections, what we've done—in accordance, actually, with some of

the recommendations from the AG—is we have updated our IT application, whereby every time now we're issuing an order, we actually generate an intake for a follow-up inspection. We set that intake up in our system, and we identify the time frame for when we need to go back in to inspect based on the compliance state that we've set up in the order. If the order was two months from now and we've set benchmarks now, we would, within 30 days or whatever it is of that, be tracking to see that we're getting back. We've changed the IT application to track that. We've set up the fields. We've set up the processes to do the intakes.

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The management reporting is our final piece so that we can actually generate those reports. That is now being finalized. By January 2017, our plan is to actually be able to generate the suite of reports to be able to monitor our performance against that.

Mme France Gélinas: It's on its way?

Ms. Karen Simpson: It is.

Mme France Gélinas: Okay. How comfortable are you in giving me the date of January, which I will hold you to—maybe not you, but you, Deputy.

Dr. Bob Bell: Rather than talking about the month, Madame Gélinas, could we talk about the season?

Mme France Gélinas: I'm willing to negotiate, yes.

Dr. Bob Bell: We're thinking of the spring of 2017. We're very hopeful. But there's no hard-and-fast rule to plan this mathematically. Our estimates are that the realignment of resources that we've accomplished will bring us a rational level of people waiting in the queue. But we all know that queue theory is difficult to predict. We all know that it's also altered by the number of complaints and critical incidents flowing in.

This is a commitment for the ministry. If we have to hire more people—we recognize that these are some of the most vulnerable Ontarians. I think that we all recognize the importance of inspection in protecting vulnerable people. We will ensure that we are inspecting in a responsible way and acting on the outcomes of those inspections. If that means hiring more inspectors—we've demonstrated, I think, that we've increased our resources here substantially over the last three years. If we need to increase it further, we will.

Mme France Gélinas: Okay. How did you come up with 100 in the first place? It's a nice round number, but how did we come up with this? How did we know that we didn't need 89 or 107?

Ms. Karen Simpson: When this happened—in June of 2013; we remember it very distinctly—the minister made the commitment to do a resident quality inspection in every home, which was something that we saw very positively and something that I think was a really positive introduction to the system.

When that happened, we were tasked with, "What do you need to make this happen?" We actually did calculations based on the number of inspector days that it takes to do a resident quality inspection, including preparation for that and completion of the inspection reports. We did those calculations. We then looked at how many of these inspections we are going to have to do in the province, did the math and came up with 100, based on the number of days one inspector can inspect every year—because, obviously, you have to take off sick leave and vacation. We have that number. We did those calculations, and the numbers came out to 100. That's how we came up with it.

Dr. Bob Bell: That part was easy. If we had 600 homes and 30 inspector days for an RQI, obviously we need 18,000 days' worth of inspection capacity. As we do the risk-adjusted approach, it's not as easy to calculate because the inspector doesn't necessarily know, going into a critical incident evaluation, how long they'll be there. So that's why we're—

The Chair (Mr. Ernie Hardeman): I just want to say that I finished my calculations, and the time is up.

We now go to the government benches: Mr. Fraser.

Mr. John Fraser: Do you want to finish the answer to that question?

Dr. Bob Bell: Just that we are making a best estimate and we will adjust it as necessary. That's why we think it's so important.

The software modification is to provide management KPIs that demonstrate how many people in each region are waiting, how many people are actually being inspected and how many complaints and incidents are being inspected within benchmark. We may need to adjust these estimates, but we're hopeful that we will be on the right track by early in 2017. I've gone from "season" to "early."

Mr. John Fraser: Thank you very much for being here today. I have some questions around resident quality inspection. But I just want to preface it by saying that, as you can hear, all of us around the table have long-term-care facilities—homes, not facilities; what an awful way to say it; homes, which they are—in our ridings. I've got the Perley and Rideau Veterans' and St. Pat's. There are almost 1,000 people who are in long-term-care beds in my community. So it is, of course, a concern to all of us.

I appreciate the risk-based approach to how we manage this. What I need to understand is the RQI methodology. How did you develop it and what was involved in that process? How did you get there?

Ms. Karen Simpson: Thank you, MPP Fraser. I'm actually quite happy to talk about how we developed the resident quality inspection, because it was a lot of work and something that has evolved into an inspection methodology and a program that actually underpins everything we do in the Long-Term Care Home Quality Inspection Program. When the government proclaimed the new Long-Term Care Homes Act back on July 1, 2010, we recognized, prior to that, that we needed to develop a whole new process and approach to inspecting to align with the act and the regulation. It was the coming together of three pieces of legislation into one piece of legislation. It consolidated program standards and guidelines for manuals into a piece of overarching legislation that governed everything we did. So we needed to

completely transform how we did inspections in the province of Ontario.

Our act is very comprehensive, as we've talked about. We think it's forward-thinking and one of the most comprehensive and forward-thinking in Canada and internationally. So we needed a comprehensive inspection process that would also make us a leader in inspections. The act requires inspectors to conduct inspections for the purpose of ensuring compliance, so that was also a change with the new legislation and a very different approach, because previous legislation talked about inspectors determining non-compliance versus ensuring non-compliance. It was an important and fundamental shift in the roles of inspectors in the mandate of the program as well as the accountability relationships between both the ministry and long-term-care home licensees.

We needed an inspection program that would focus on risk management, quality of care and quality of life for residents in homes. So what do we do? We looked for a redesign to our inspection process to ensure that residents continue to be protected and cared for, and dignity and rights respected. We wanted to also substantially eliminate variability and inconsistency across the province, because those were criticisms we'd had before. We also had a paper-based inspection program, so we needed a program that could also be IT-enabled and support the sector in its efforts to develop quality care while also enhancing our ability to identify and mitigate risks.

So how did we get there? We conducted an interjurisdictional scan of inspection systems not just within Canada but internationally. We looked across Canada; we looked at Australia; we looked at Europe and we looked at Scandinavian countries, as well as south of the border to the United States. Many other countries internationally don't have inspection systems; they have accreditation systems. We were looking specifically at systems whereby they actually were inspecting.

The results of our research and our interjurisdictional scan showed that there was a new inspection methodology that was just being implemented in the United States called the Quality Indicator Survey. In the US, they actually call their inspectors "surveyors." That system best reflected the goals that we had in place to move forward with our compliance program under the Long-Term Care Homes Act. Careful analysis of the Quality Indicator Survey process identified that about 85% of the care areas within our own act were being picked up in the QIS process. It was resident-centred, and what I mean by that—and that was one of the fundamental principles that we were looking at—is that residents, families and staff were interviewed first. So the focus of the inspection was driven by what the residents and families were telling us. That was very important to the new methodology as we moved forward.

It also placed an emphasis on quality and the resident, and that wasn't just quality of care, because what we also hear from residents is that quality of life is just as important to them as quality of care. Both of those issues are very important. It was a very structured methodology that drove consistency in inspection, so it made sense for Ontario to adapt the Quality Indicator Survey and align it with the requirements of the Long-Term Care Homes Act.

To do that, the ministry obtained expert advice and support to redesign the inspection system. We brought Nursing Home Quality out of the United States through a request-for-proposals process. They tendered, and they were the successful vendor.

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The lead principal at Nursing Home Quality was also the lead researcher. He's a physician out of the University of Colorado who worked with researchers all across the United States to develop the Quality Indicator Survey. We were very fortunate to have their interest in moving this forward.

Working with our program, Nursing Home Quality adapted the QIS methodology, policies, procedures, education and technology to Ontario. Alongside our Ontario team, they tested, analyzed and revised all aspects of the QIS to ensure alignment with the Long-Term Care Homes Act. It resulted in a truly resident-focused process, a made-in-Ontario solution, the resident quality inspection, which we now know as the RQI.

What happened in the United States to require them to develop the Quality Indicator Survey? At the time it was being designed and adapted in Ontario, in 2009-10, the Quality Indicator Survey was the result of over 15 years of research by the team of researchers, which was led by the principal from Nursing Home Quality, out of the University of Colorado. That research was funded by the Centers for Medicare and Medicaid Services in the United States. It's actually publicly available methodology in the United States.

We talked to CMMS at the time. They were very supportive of Ontario's request to use it as the base methodology for adaptation in Ontario. The research in the United States began following the introduction of the federal USA omnibus budget reconciliation legislation, OBRA, which included the Nursing Home Reform Act.

This legislation came into being because of an evaluation of the US nursing system which identified issues within the system that needed to be addressed. Many of those issues were very similar to the reasons behind the introduction of our own Long-Term Care Homes Act and ensuring, in legislation, that we had enshrined all of those principles and rights of residents and the requirements to ensure the safety and security of residents.

The objective of QIS was to increase consistency in inspections, design a more comprehensive inspection system, enhance documentation and target inspection resources. We in Ontario were also looking to achieve the same objectives.

That process featured rigorous training requirements for inspectors; adherence testing, actual testing of inspectors to ensure they've got it right and that they apply it properly; desk audits to ensure consistency; IT automation; and a team-based approach to inspections.

Feedback from the US nursing homes interviewed on the QIS experience said that there was greater fairness in the inspection approach, standardization, clarity and focus. There was an increased number of non-compliances, as every example was a non-compliance.

The length of the inspection was longer, in many cases, than their previous inspection review. However, education for long-term-care home staff and increased communication with the home became critical, because homes were able to have the methodology, apply it in their home, and should be able to identify the issues without an inspector even coming in the door. That's actually the same principle we try to use here in Ontario.

Homes changed their quality programs to identify, follow up and address resident and family concerns, and quality assurance mechanisms became critical. Areas of risk were identified.

What did we do to adapt it? We did a thorough analysis of the areas reviewed within the QIS system and our own legislative and regulatory requirements under the Long-Term Care Homes Act. We made substantive revisions to ensure alignment with our own legislation. We developed inspection protocols for our Ontario team, working with the vendor, to ensure that they reflected the content and requirements of the act, and to guide inspectors and drive consistency in inspections. We actually have 31 inspection protocols guiding our program.

We tested the new inspection process. We had teams of inspectors, administrative support and experts from Nursing Home Quality testing the process over two months in homes in Ontario.

The stage 1 process and stage 2 inspection protocols were also tested, and that process included content analysis to ensure that questions and assessments were relevant and clear from the residents, family and staff perspectives and that inspectors looked at the right areas that were critical to resident quality of care and quality of life.

We also did analysis to ensure we were triggering the right areas, that we were triggering areas where there really were care concerns, so not sending inspectors into areas where in actual fact there was no problem in that home. We got feedback. We had evaluations and feedback from residents, families and staff. We heard very positive feedback from families and residents. They felt that the process—staff indicated the process was more objective. They felt their issues and concerns were being heard. The most important piece for us was that residents said this was the first time they were feeling heard in an inspection process, that their issues were really coming to the forefront and that we were responding appropriately.

What did we do next? We revised the questions from the stage-1 process. We revised the inspection protocols. We ensured policies and procedures were in place, and we developed a training program for our inspectors that involves not just training but certification. They're actually tested to ensure that they can apply the methodology appropriately.

Training includes one week of classroom training and four weeks' training in the field, including conducting an RQI with a trainer to ensure the inspector applies the methodology appropriately. Inspectors have to be certified before they can conduct these resident quality inspections on their own. They were trained by master trainers who are firstly trained and adhered to conduct resident quality inspections themselves, and then went through additional training and certification to train inspectors on the methodology.

Training of master trainers includes being certified to conduct classroom training, observe and support inspectors in the field when applying the process and ensuring the inspector has understood and is able to conduct the resident quality inspection.

Mr. John Fraser: Go ahead.

Ms. Karen Simpson: One of the key features of the resident quality inspection is that residents' voices are heard. Interviews with residents play a central role in information and evidence gathered during an inspection and actually drive further inspection by the inspector.

It's a two-stage process. Residents are interviewed and observed. Families and staff are interviewed and documentation is reviewed as part of that stage-1 process. Inspectors can access interpretive services if they're speaking with a resident who doesn't speak the language of the inspector. Questions for residents were tested to ensure the questions were clear and easy to understand.

Mr. John Fraser: May I interrupt you for just one second just to get a clarification?

Ms. Karen Simpson: Yes.

Mr. John Fraser: So on both the complaint and the—I'm sorry.

Dr. Bob Bell: Incident?

Mr. John Fraser: The critical incident—that methodology is applied to both of those?

Ms. Karen Simpson: Yes. What we actually did was, when we developed the resident quality inspection, which is a comprehensive inspection, we took all of the principles and applied them to the methodology for our complaint inspections and our critical incident inspections. When we go in to do a complaint, we also train our inspectors to, again, talk to the resident who is the subject of the complaint—obviously it's more focused—talk to families, get their input and talk to staff. So it's not just a documentation review; it is actually again, even in those types of inspections, the resident and family concerns that would drive the inspection process.

Dr. Bob Bell: Just to give Karen's voice a rest, the remarkable thing is that this is all embedded in the software system that ensures absolute standardization of the process the inspector takes either for an RQI or for a complaint or incident-based inspection, which also has the advantage of standardizing the conversation between the home and the inspector in our long-term-care branch. That standardization of quality, we think, is an important additional feature that this inspection process brings to us.

Ms. Karen Simpson: What I'll also add—and it's not in my notes, but we shared all of the inspection protocols, the questions we ask of residents, the question we ask of

staff and families, what we look at, because our inspectors also observe what's going on with that resident, their environment, continence issues.

We've shared all of those tools and templates with the sector because what we want them to be able to do is to take that information and embed that in their own quality assurance program, and we know that homes are doing that.

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Mr. John Fraser: Actually, that's sort of part of where I was going. You've got this risk-based approach to it, but you have this critical incident, and a critical incident is—I'd like to better understand the definition of that. That's an internal reporting process, so what I would hope is that you've got an internal reporting process where internally they have to report to you. They have to report internally and they have to report to you so that in the process of reporting to you—initiating whatever—remediation or correction or investigation occurs there, right?

Dr. Bob Bell: This is an important principle, I think, Mr. Fraser, of what the program is. It's not a gotcha program. It's a quality improvement program where learning occurs on both sides. We want the long-term care to be engaged in that quality improvement journey with us. We want them to look for opportunities to improve their care and educate us as to the incident that's been observed by their staff, and allow us, as part of the inspection process, to share best practice not only with them but with other homes subsequently.

This is really the fundamental principle of a learning organization approach to quality. Our inspectors learn, we learn in the branch and the homes learn from each other's experiences.

Mr. John Fraser: Do you want to add something?

Ms. Karen Simpson: I was going to add to your point about the critical incidents. There is a requirement that the home does their own investigation and incorporates the learnings from that investigation and the actions they've taken into their own quality management program, as the deputy was saying. It's not just us having to inspect and them having to report to us; they also have a responsibility themselves.

Mr. John Fraser: What's the breadth of a critical incident? It goes from somebody got lost for a day to—what's the scope? How small or how big is it, so I understand that?

Dr. Bob Bell: It could either be harm or potential harm to a client, to a resident, that is being reported. To give you the scope of what that could actually represent, I'll turn to the expert.

Ms. Karen Simpson: We have two sections of the act and the regulation that actually speak to the reporting of incidents. The first one is section 24 of the act, which is mandatory reporting. It speaks to abuse, neglect, improper care or harm, those types of things that are required by the Long-Term Care Homes Act.

Then we have section 107 in the regulation which speaks to another category of critical incidents that need to be reported, which includes the resident who may go missing, or a breakdown of systems within the home, i.e., if there's a power outage for more than three hours they need to report that. There's a whole range of types of incidents and types of issues that need to be reported under 107. It's very comprehensive, ranging from the really serious—they're all serious, but abuse-harm right down to that person who may go missing for more than three hours and the home needs to address that.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll now go back to the official opposition: Ms. Munro. Before we go any further, it's 18 minutes per caucus this time around to use up all the time.

Mrs. Julia Munro: Thank you very much for coming today to give us some very interesting material. I think all of us have either relatives or friends—we're not far away from this process in terms of being either a relative or friend or something like that.

It's extremely heartening, despite what we hear outside of these walls, to know that these kinds of initiatives have moved along in being able to look after the people who live in long-term-care homes.

I think probably the most delicate part of the whole operation for a family is that, like it or not, they feel they're abandoning the family member. Part of that, then, goes to the very heart of what I think is behind the changes that you have undertaken, and that's the question of risk management: how and why, and what are the circumstances and what are the chances of needing to use risk management?

I'll just tell you one anecdote. It actually was in a retirement home. I was waiting for my mother, who was coming down from her floor. There were two ladies sitting in the lobby, and they started an argument. Then one hit the other one.

I was looking around immediately for somebody from the staff to make sure that this got under control. Well, they were sisters. They had been doing that all of their lives. It wasn't really quite the crisis management that, naturally, I thought was potentially the problem.

I think that people do appreciate the kinds of choices that you have made in organizing and setting forth.

There are two things that I see, as the discussion has taken place today, in terms of a line: One is the growth of the need for those long-term-care beds and that trajectory; the other is to look at the kind of risk management protocols that you've put in place and the training for the people.

Are they going to meet? Are we going to have enough beds? Are we going to have enough inspectors? Just a quick question.

Dr. Bob Bell: Let me start off by saying that this is one of Associate Deputy Minister Sharon Lee Smith's key responsibilities for the Ministry of Health, and that's to enhance our ability to put in place really robust methodology for capacity planning.

Maybe I can ask Sharon Lee to respond to that, and maybe ask Acting ADM Brian Pollard to talk to the issue of responsive behaviours and investments that we've

made related to behavioural support units and Behavioural Supports Ontario. Would that be okay? Because I think that these really are important for the committee to understand.

Mrs. Julia Munro: Certainly.

Ms. Sharon Lee Smith: Thank you for that question. It is a very important and prescient question, I would say. Again, Sharon Lee Smith, associate deputy minister for policy and transformation.

We are working on some capacity planning for the ministry for the entire continuum of care to understand where demographics and the health needs of the population are going to take us in the future, using qualitative methods, but also quantitative methods—predictive analytics, if you will—to understand our future better.

We decided, in our capacity planning, that the place really to start was looking at our seniors population and looking at the growth in our demographics in our aging population, particularly people who are 75 and over, because that population is going increase dramatically in the next two decades. Now, way into the future, it falls off, but you have to plan for that as well.

In our planning, we are understanding that there is always going to be a need for capacity in the long-term-care system. There is going to be a need for beds. We're going to always have to make the right choices about that. But we're also understanding that, more and more, people want to age in place. They want to live at home and they want age-friendly communities.

Some of the data that we are looking at—we're starting to think that we need to make sure that we're making the best possible use of the entire health care continuum and all living options that are available, or incenting or improving options that might be good alternatives to long-term care.

We're always going to need long-term care, but what about other types of assisted-living arrangements? What about retirement homes that perhaps have more care offerings? What about—particularly, I would say, I am very focused on the north in terms of a lot of my portfolios—rural and northern areas where you don't have as many assisted-living options?

We are looking at that broader range to decide where we might want to be making some policy advice for decision-makers on what types of other approaches we can take. Now we obviously want to keep long-term care viable and we know we are always going to need it. But if we did nothing in the long-term-care space and just let demographics take us to where we need to go, we know we will be building more beds that, in a couple of decades, we may not necessarily need.

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People want choice. We are very excited about this work. In particular—and I'm going to throw it over to my colleague—we are understanding, in our capacity planning, that the dementias and the aggressive behaviours and the needs for people with complex behaviours—our demographics are shifting. We are getting more frail seniors. We need to make sure that we are very, very clearly understanding the dementia population and where it's going to go in terms of numbers and what the best practices are to manage, both in long-term-care homes and other areas of the community.

I will turn it over to Brian.

Mr. Brian Pollard: Thank you, Sharon Lee. Brian Pollard, acting assistant deputy minister for the long-term-care homes division.

It is a question we wrestle with every day in terms of how many beds. I would say, to build on what Sharon Lee has said, it's no longer just a question of how many beds but what type of bed. As the inspection system is clearly telling us where the pressure points are in the system and what kinds of critical incidents we're receiving, we are really looking at our behavioural support units—and we have five of them in the province—to understand if that is a potential model, if you will, that we should scale across the province. As I said, there are only five of them—clearly, demand for more of them. They're there to service the most highly acute patients in the residences in the area of behaviours. It supplements some of our other strategies, specifically BSO, the Behavioural Supports Ontario Project, which we continue to invest in, and is really targeted at support in residences of responsive behaviours.

We have a few other programs within the ministry that also support additional in-home supports and long-term-care homes supports. In totality, what that tells us is ongoing need for long-term care but not just a bed for the sake of having a bed—so in alignment with population growth, but certainly specialized beds.

Ms. Sharon Lee Smith: If I may, I just wanted to raise another point. One of the things we're finding in our capacity planning is looking at some of the reasons that tip, if you will, people into long-term care. We're not coming up with magic answers; they're very predictable answers. But through our modelling we're getting an evidence base to be able to really ascertain to decision-makers that we understand why people need increased care. Some of those reasons are very simple, if you will. Social isolation, incontinence: These are issues that, if we can better manage them outside of the long-term-care continuum—if we can look at our home care supports and our other types of community living supports to make sure people aren't alone, that they have people to have dinner with, that they are getting, perhaps at one point, their lighter care needs met—we won't see necessarily the decline or the increase in frail seniors.

This is the kind of space that we are really trying to do more work on in the ministry, learning from our inspections process in terms of what our inspectors are seeing on the ground and how we can resolve it.

Dr. Bob Bell: Two of the most valuable things that are going on in the Ministry of Health right now, Ms. Munro, in terms of the future of the sustainable health care system, are the capacity work that Sharon Lee has described and, second, also in her portfolio, the dementia strategy for Ontario. If we can simply maintain folks with progressive cognitive decline in their homes for an extra 18 months by putting in place best-practice, standardized

primary care and home and community care, we can dramatically reduce the number of long-term-care beds that would otherwise be necessary.

As Sharon Lee mentioned, if we continue our current practice and just project forward based on the future demography of Ontario, we could be looking at 115,000 new long-term-care beds needed above the 75,000-plus we have today. Clearly, that's not what Ontarians want. The issue of how we allow people to age in place, with dignity, with safety for their families and their personal safety, is one of the key issues for our ministry.

Mrs. Julia Munro: Thank you. I thought it was important for us to get a sense of where that part of the process is coming from.

Dr. Bob Bell: Thank you. We appreciate that.

Mrs. Julia Munro: But I want to switch gears and go back to the risk management that you deal with in regard to supervision and oversight, things like that.

Having made a number of studies from the demand for a review of inspections, what have you gained in terms of the cost of those inspections? We have 100 people; we have, obviously, wait times of trying to get things resolved, so clearly some parts of that are dangling, they're not caught up in the mainstream of risk management of what you're doing. So my questions really come from the idea of what's out there that's still dangling on that list of things to do? How much does it cost? Can you identify where—after you've dealt with this process of management, I'm assuming that you're going to get a higher level of response from the homes, because obviously they don't want to be part of this process on a regular basis; they want to be in the clear. What kind of speculation or adjustment can you make in terms of the costs as you go forward? It's another go-forward question.

Dr. Bob Bell: Let me start off there, then perhaps Karen would like to think of her comments.

I think we're in a very interesting position, in that we've now done very remarkably robust evaluations of the quality of care and the quality of the infrastructure available in all our 600-plus homes, using 30 person-day inspection processes two years in a row. Not only have the homes learned a lot about the requirements they have under the Long-Term Care Homes Act, but we've learned a lot about those homes. They've also learned about processes necessary for their improvement.

I want to go back to the comment that we had with Mr. Fraser, and that is the fact that this organization—the long-term-care-home industry, with the inspectorate, with the long-term-home-care branch—is truly becoming a learning organization. This is very powerful and positive. If you look at the literature of quality, this is what you want to achieve, to get quality improvement.

Interjection.

Dr. Bob Bell: Sharon's mentioning the keyword: You don't want to get an adversarial gotcha approach; you want to get a culture of continuous striving for improvement, the sense that you're never going to rest to improve quality. There's always an opportunity to make quality better, and that's what we think we're progressing toward.

So in terms of the cost, I'd say that the cost of developing that culture, whatever that cost is, is well worth it, because we are dealing with, as we've talked about, some of the most vulnerable people.

The culture extends not only to the interaction between the ministry and the industry, but also to the interaction between people in long-term-care homes themselves, who've previously, perhaps, been thought of as a part of the health care system in Ontario as a bit below the radar screen. But we're now recognizing, with the focus that we have on capacity planning, dementia strategy planning and this real emphasis on inspection, that indeed, this is the future of sustainability of the whole system: how we care for increasingly frail, elderly folks.

In terms of the cost, the cost is managed in part by utilization of technology. This is extraordinarily important for us: an inspector goes into a home with—depending on the complaint, depending on the critical incident—a very well-structured approach that's standardized. The home knows the questions and the family council knows some of the questions. That's critically important in containing costs.

The other is to have the appropriate supports for inspectors. I know, Karen, you've invested a lot in the education of inspectors and in the management of resources that support inspectors to ensure that our part of this learning organization can be developed and that inspectors aren't simply doing the same thing; that they're actually improving in their function. Is that fair to say?

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Ms. Karen Simpson: Absolutely. With the Auditor General's recommendations, we actually developed a very, very detailed—it's this big—plan with deliverables, and included in that was an education and training plan for our inspectors, because we obviously have to educate and train in all of the changes we're making, as well as ongoing training for their own skill development. To do that, we have a new education manager who has come on board to work with us, who's just amazing. We have brought on some trainers, and we have plans to bring on more trainers across the province over the next X number of months. That is an area we're really focusing on because we want to ensure that we've got the best people out there and that we have excellent staff who have the right supports to do their job well.

The other piece, just to build on what the deputy said, is we have two years' worth of data from the first two years of resident quality inspections. What we saw in the second year was a significant improvement by homes in their performance, through the resident quality inspections. We saw the number of orders issued go down by 50%. We saw in homes that were issued non-compliance in the areas of, for example, infection prevention control a 30% reduction in the number of homes that had issued non-compliance in that area. Consistently, we saw that improvement by most of the homes in the sector.

Where we have the problems from a risk management perspective, we need a robust mechanism to address that, and we're also dealing with that as well.

So the sector is responding. Health Quality Ontario reports on key indicators. We're seeing improvements in that area as well—improvements in use of antipsychotics, other areas.

From a risk management perspective, it's really important for us to identify—we still have some room to go to look at those new enforcement options, to get all our management reporting in place—

The Chair (Mr. Ernie Hardeman): Hopefully, that will fit with the next question. That concludes the time.

We'll go to the third party. Ms. Gélinas.

Mme France Gélinas: In her report, the auditor talked about providing the public with better information. I know that the resident quality improvement inspections are eventually online—not always on time, but they eventually get there. I consider myself an average-intelligence person, and it is really, really hard to understand one of those, and I spend my days and nights looking at our health care system. Is there any hope in sight that we will put something forward that will be family-friendly?

I will start with this: We have used repeatedly that 80% of the homes, within the first two years of comprehensive resident quality improvement inspections, have done very well and 20% have not. I am absolutely incapable of finding out which of those 630 homes fall within the 20%.

Dr. Bob Bell: We've established benchmarks for the first stage of what you're describing; that is, completion of the inspection report, finalization of the report, and then the issue becomes timely posting of the report as well. These are key performance indicators that management is now tracking. We're monitoring the posting of inspection reports to the public reporting website, but crucially we also think these reports need to be understandable and they need to provide Ontarians with real information about choices they want to achieve with thinking about their loved ones and where their residence will be. As of one month ago, we've launched an improved website—we think—which is more public-facing, to allow the public to see how one home compares to the provincial average.

We're also engaged with Health Quality Ontario. As you know, Health Quality Ontario has the responsibility of a holistic demonstration of quality, and they've developed real expertise in how to represent quality information to Ontarians so it's understandable. Their annual reports and their between-report postings on their website can centralize some of this information and make it understandable.

Karen, I know your team is really pleased with the new website. Have we had any comments from either residents or family members to date? I know you engaged both residents and family members in the development of the website. Can you tell me about that?

Mme France Gélinas: And if, in that process, you could answer my question, which is, is there a way to identify which homes are part of the 80% and which homes are part of the 20%?

Ms. Karen Simpson: Right. I'll just respond to that question first of all.

Where we rate home by risk is a fluctuating process. We actually run the numbers quarterly based on a preceding year's worth of data. However, that status of a home can change today. If we get information in the door about some serious issues, a leadership issue or a financial issue, that moves that home, from a risk perspective, today.

We have looked at other jurisdictions to see how other jurisdictions actually rate homes. It's very difficult to do that in a way that isn't subject to change in the instant. In fact, it has failed. In the States, they were using five-star, four-star, three-star type methodologies, and it didn't work because the data doesn't catch up in time to actually have real-time reporting.

That's why we introduced the website upgrade, which came in in September. We actually worked with residents' councils, family council reps and stakeholders from the sector and looked at what would be meaningful to residents and families. So what we've done is we've launched the website, working with communications on the ministry's public site. It compares how many inspections are being done, how many non-compliances and how many orders against provincial averages so that the public can actually see how that home is comparing against other homes in the province. We've done that.

The other piece that is in our action plan—we've just been a little busy with a few of the other ones—is to actually update our inspection reports. We understand that, for many people, inspection reports aren't always easy to understand. We also have a lot of people who say to us, "We want that level of detail." What we're looking at is getting together with the stakeholders in the next three to six months to find out from them how we can actually improve, maybe by having an executive summary page that could be pulled from data so that individuals who just want that quick snapshot can get that: How many non-compliances were issued, and in what areas? What were the major concerns? Were there any orders? Where was it? So we can actually do that. That's part of our plan as well to improve the process.

Mme France Gélinas: Will we see within that plan the critical incidents that the home has reported and the number of complaints that were made against that home?

Ms. Karen Simpson: That's something we could actually take back and look at.

Dr. Bob Bell: The concern about critical incidents reports being interpreted as a sign that the home is not doing their job is one of the issues that always comes up in quality improvement plans. That is, we want homes to report critical incidents that occur so they can learn and we can learn. If that is then used as a signal that it's a low-quality home on public reporting—that's something that family councils are actually responsive to and understand. But it is a bit of a concern in terms of a five-star kind of approach to ratings.

Mme France Gélinas: Sticking with the critical incidents that the home has to report, how confident are you

that all of them are being reported in accordance with the law?

Dr. Bob Bell: I think it's fair to say that 100% can't possibly be recorded. That's why we want them to be—the most important thing in terms of that culture is to emphasize the fact of learning, emphasize the fact that this is part of improving quality in a home and to say, "We are delighted that there are more critical incidents being reported from your home. It gives us an opportunity to improve." So I'm sure that we have not seen all critical incidents being reported. We've seen, this past year—I believe the number went up by 1,000?

Ms. Karen Simpson: About, yes—just under 1,000.

Dr. Bob Bell: Just under 1,000. We see that as a good sign. I don't know where we top out, but this is part of that quality culture.

Mme France Gélinas: Okay, I get the idea between the quality culture.

At the same time, there is a demand from people who are trying to select a long-term-care home to know if there have been repeated missing-patient critical incidents in that home. If you know that your mom still wanders, maybe you'd like to know this and put her in a home that has a more secure unit, or on a second floor or whatever. Is there a middle ground there, where some of the critical incident reports will become available?

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Dr. Bob Bell: I think one of the issues relates to the issue that acting ADM Pollard brought up, and that is the fact that we need to be better at segmenting the population of folks requiring long-term care and the kinds of resources that we can provide them with. If your mom is wandering, if your mom is suffering from cognitive decline, we need to have more behavioural support units, we need to have more support. I think, Brian, we're now providing $53 million in funding annually?

Mr. Brian Pollard: Fifty-four.

Dr. Bob Bell: Fifty-four million annually in funding, as well as hiring staff who have special expertise in responsive behaviours.

Part of the answer to your question is to describe whether or not a home has these special resources that are appropriate to your loved one's needs. But I think we're hearing you and we're thinking through this concept of how complaints and critical incidents perhaps could be structured on our new, improved, patient-facing, family-council-facing website, and how we can make that more responsive.

We do have a system that we use internally: a ranking system for long-term-care homes based on the past two years of data. But, as Karen said, we don't want to put that out there and then have it change in the moment with a new inspection resulting from a complaint. If you learn that the home just dropped 10 points based on a complaint being registered—we don't know that that ranking system is robust enough at this point to actually provide that to Ontarians as a real option for them to use, a real tool for them to use in making important decisions.

But you're right: We do need to have more information there that is understandable. That is one of our commitments.

Mme France Gélinas: You came to this committee and you used those numbers— you used the 80% who did very well during two years, so they will go on for a third year, and you used the 20% who will continue to be under a yearly comprehensive. As we speak right now, could you share with us who they are and, basically, how you come up with the 80% and 20%, and can we verify those numbers?

Ms. Karen Simpson: As we've noted, every long-term-care home is still getting a comprehensive resident quality inspection. Some are more intensive than others. Even the risk-focused approach to the RQI is 10 inspector days. It's not a couple of days; it's actually to inspect us for five days, plus they are often in there longer because they're also conducting complaint or critical incident inspections at the same length of time.

The other reality is that today we may have scheduled a shorter inspection for a home and then we get information once in the door. That inspection transitions to a more intensive one even during the inspection if we identify that there are risks that are coming forward from that inspection.

As far as your point earlier on critical incidents and complaints, that's why we publish inspection reports. We publish inspection reports related to critical incidents and related to complaints. Many of those complaint inspections or critical incident inspections are looking at many issues. So we have a critical incident inspection that may actually be dealing with five different critical incidents or 10 different critical incidents, and all of that information is in the report. We do try, as much as possible, from a transparency perspective, to ensure that the public can access that information on the ministry's website.

Dr. Bob Bell: I guess what we're saying is that all of our information is posted there. What we are not doing at this point, because we're not sure that it's accurate or that it would serve Ontarians well in making decisions, is to do some sort of ranking system. If a home is in that group of 80% and they're currently, we think, low-risk homes, and, during the course of a complaint or an RQI, we find it has changed, then people would have to look back at that decision in the moment. We're not sure that we have a robust enough ranking system, I think it's fair to say, for Ontarians to really rely on that. Maybe a year or so from now we'll be changing our minds, because this is something we're looking at, but I don't think we're there yet.

Mme France Gélinas: I would ask you to just share with the committee what you have right now—pick a day. Where does that 80%/20% come from? You've used this number a number of times. You used it in your opening remarks. I want to have a little bit of background information that brought us to this.

The other part is that it was really interesting when you were answering a question from Mr. Fraser about how our inspections came to be. When we did the switch

from—what did I call it?—comprehensive to a different intensity, how did you go about deciding what questions will remain and what questions wouldn't be there anymore?

Dr. Bob Bell: Let me just go back to the issue that you raised first about the 80%/20%. The thought that 80% of homes are substantially in compliance is based on a variety of things. It's based on the RQI plus investigations of complaints and critical incidents. So multiple data points are providing us with that information.

In terms of the development of the risk-based approach: Karen, do you want to describe how that came about?

Ms. Karen Simpson: Yes. When we received the Auditor General's recommendations, we actually re-engaged with Nursing Home Quality because we still have a contract with them, because we have an IT solution for stage 1 of the RQI process that we use. We have a contract in place.

They have a scientist as one of their staff on board, and other researchers. What they did was they got the results from the last two years of inspections and received, I think it was, about 5,000 data elements from all of those inspections. What they looked at was what triggered resident quality inspection, and then if it led to non-compliance.

What they identified was that there were many areas that were being triggered and where inspectors were looking, and there was no non-compliance. They compared that to the better-performing homes. What they focused on was, where we were actually identifying the non-compliance? That's how we structured the new approach to our resident quality inspections. We used the evidence and data that we had sourced over the last two years. We had an objective, independent expert provide us with recommendations. We tested it to make sure that it would work. We'll continue to evolve as we move forward.

Mme France Gélinas: The questioning of the patients, their families, the resident council and the family councils: Are those four areas maintained?

Ms. Karen Simpson: Yes.

Mme France Gélinas: All four of them are? Identical to whether you were getting a comprehensive or a—I don't how to call the light one.

Ms. Karen Simpson: The only changes we made were, instead of up to 40 residents, we're interviewing up to 20 in the better-performing homes. We're still interviewing the residents' councils. With family councils, we have options. We have a questionnaire they can do by email, because we actually heard from many families that that was easier for them to respond to. They can also meet in person with our inspector or have a telephone interview, depending on what their preferred way of moving forward is. We heard from family councils that that actually was a positive step for them, because many of them are busy working during the day, and it was easier for them to reach us that way.

Mme France Gélinas: So will that be available in both, whether they are comprehensive or—

Ms. Karen Simpson: Yes.

Mme France Gélinas: It will be available to both?

Ms. Karen Simpson: Yes.

Mme France Gélinas: Okay. Very good. If I focus on complaints: They put in a complaint; an inspector goes and does an inspection based on the complaint. Is there a role for anybody within your department for advocacy for change? They go in, they see that there is non-compliance or there is an issue. Where does the advocating for the patients for change versus letting the home figure it out—where does it end and start?

Dr. Bob Bell: This is not just about assigning blame or identifying error; this is a solutions-based inspection process. We're suggesting what the best practice is and what we've found from other homes. Part of the value of this is that you have somebody on the spot who has seen solutions in other jurisdictions or in other areas of the province. I think that's a pretty substantial part of the value of having the individual there.

Ms. Karen Simpson: On the specific issue that you raised, Deputy, when our inspectors go in, if they identify issues, if it's a serious issue they will issue orders and ask the home to come up with a plan to actually resolve that issue. The inspector may also suggest that they've seen another home that has resolved the issue. But they don't actually provide advice to the home because you can't then inspect against your own advice. But they would provide options to the home of maybe where they could go to look at it.

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I think the other critical piece is that the information from our inspections is being fed into policy development options in the licensing and policy area of our division. That's actually where Brian also works. We see issues related to resident-to-resident behaviours, antipsychotic use, restraint use, whatever. We can feed the data that we get from our inspections—which is why we've got this great IT system now to support that—

The Chair (Mr. Ernie Hardeman): Again, I think we'd better take that answer and put it on to the next question, if we could. We now go to Mr. Rinaldi.

Mr. Lou Rinaldi: I guess it's between me and finishing the day, right?

We know that we're all different. When one of our loved ones goes to a home, they might be of different need or different circumstances. I have a mother who's in a retirement home with lots of assistance. I know some of the challenges that we face. She's certainly not the same as her next-door neighbour—or the next room down the hall—when I visit. Bearing in mind that people's behaviours are different, can you give us an overview of the work under way to support long-term-care homes when dealing with residents who have these different, challenging behaviours? Can you zero in a little bit on that?

Ms. Sharon Lee Smith: I'm going to start off, and then I'm going to pass it to my colleague Brian to give you more details.

We'd like to thank you for that question because in the Ministry of Health and Long-Term Care we are very

seized with the issue of dementia and the toll it is taking on patients—residents—and their families, as caregivers. We are embarking on a dementia strategy development. We're in our second phase of public consultations. In fact, the first kickoff of the second phase was last night in Thunder Bay. When we worked to get the dementia strategy in development about a year ago, along with our capacity planning work on dementia, we were thinking that we would do a six-month strategy and work very intensively. But we were actually advised to take longer to develop this strategy, given the significance of the disease state in our long-term-care facilities—frankly, in our communities and right back in to our hospitals, because it is showing up in patients in hallways, patients coming to emergency departments because families are struggling. So we really want to take the time to get this right. We are engaging with the public, with medical professionals, with experts in the field, with folks who are implementing best practices. We're looking at other jurisdictions as well. We really want to make sure that we are understanding what we need to do and, in particular, building a strategy on what we are already doing in some of our successful programs.

Thank you for the question, because I think our inspectors are seeing the impacts of people with dementia. Our hospitals and our communities are seeing the impacts. We have to get this one right.

I'm going to turn it over to Brian.

Mr. Brian Pollard: I'm Brian Pollard, acting assistant deputy minister for the long-term-care homes division.

It's a fabulous question and I share Sharon Lee's thanks for asking it.

Complex behaviours is one of these areas where we are now able—back to Madame Gélinas's question—to marry the inspection data with clinical data that we get out of the RAI, or the resident assessment instrument tool, with financial data coming to the ministry to really identify where the cohorts of residents are the most challenging. One of those cohorts is complex behaviours.

We have worked to address this cohort, if you will, through a number of interventions. Many of the interventions cover legislation, programs, initiatives and best practices. They include, if you will indulge me for a second, not only our acting regulation, BSO, as the deputy has mentioned, or Behavioural Supports Ontario; behavioural support units; our high-intensity needs funding program, which I'll talk about shortly; our centres of learning, research and innovation, which provide a very strong educational support to this population; and ongoing consultation of experts in the long-term-care-home sector, much aligned with what Sharon Lee just said.

I'm going to take a little bit of time to just go through each of those in detail, because they actually form part of a pretty sophisticated puzzle that all comes together to support this population.

On the first one, in terms of the legislative authority for long-term-care homes, long-term-care homes are required to have a training program that is evaluated and updated at least annually. As part of that training program, the regulation and legislation provide areas that all staff must receive training in. I'm just going to give you a few examples of that. One would be abuse recognition and prevention; the second one, mental health issues—so targeted training for staff on an ongoing basis, including caring for patients with dementia and also behaviour management. So right in our regulation, that is a requirement that homes must comply with.

To support that, the ministry has provided funding for long-term-care homes to increase direct care, provide staff training and development opportunities that focus on improving resident safety, preventing abuse and neglect, and advancing quality of care for residents with responsive behaviours or other specialized care needs. Now, we've done that in a few different ways. One of the ways was that in January 2013, the ministry invested $10 million in one-time training funding for long-term-care homes to provide staff training and development opportunities that focus on improving resident safety, preventing abuse and neglect, and advancing quality of care.

As a result of that investment, long-term-care homes reported to the ministry that that particular investment resulted in approximately 47,000 individuals, or an average of 77 staff per home, receiving training and development opportunities, with the vast majority of those staff working in what we call the nursing and direct care area. The funding has also enabled long-term-care homes to update their annual training and orientation plans and purchase 7,000 resources to support training and development. More than one third of homes took advantage of training resources developed through the Behavioural Supports Ontario initiative, so that was a second avenue through which homes could avail themselves of training dollars.

To continue, in January 2014, we then followed that up by providing an additional $10 million in one-time funding for further long-term-care home training and development for approximately 44,700 direct care staff, with the same focus as I've mentioned before. To ensure accountability, long-term-care homes are also required to report to the ministry on how they use this funding. Again, that goes back to part of our continual data gathering and how we inform policy and the programs that we want to design and implement in the system.

The majority of staff received training to support the care of residents with complex and responsive behaviours and for the prevention of abuse and neglect. The funding also enabled homes to purchase approximately 46,500 resources, so very similar to the previous year, to support in-person training. We've done funding in consultation with the Long-Term Care Homes Act and regulation to support staff training.

The other major initiative we have—the deputy spoke about this earlier—is Behavioural Supports Ontario. Again, it was designed in recognition of an increasing cohort of responsive behaviours. In 2011-12, the ministry launched BSO to implement a framework for care to support system improvements for older people with

cognitive impairments who exhibit challenging and complex behaviours, wherever they live. I think this is an important feature of this program: wherever they live, at home, in long-term-care homes or elsewhere.

Between 2011-12 and 2012-13, we invested $59 million, if you want to call that start-up money, to successfully implement BSO. That included the hiring of over 600 new staff to meet the needs of residents with challenging and complex behaviours. As of summer 2013, the implementation of BSO was completed, and we then transitioned to a more steady-state process with the Hamilton Niagara Haldimand Brant LHIN taking the lead for management of this program. The CEO of that LHIN is the point of contact for the BSO program.

Through BSO, a provincial framework of care was implemented across all 14 LHINs, so we've implemented BSO provincially, and it integrates new, locally appropriate service models, including the establishment of long-term-care home specialized behavioural units and behavioural outreach teams.

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We really left it to the LHIN to design how this should be implemented on the ground in concert with their mandate. As part of that, standardized care pathways best practices and measurements were created by HQO.

Between 2013-14 and 2015-16, the ministry provided $44 million, and I'm happy to say that for this year, we added another $10 million to get to the number the deputy just mentioned, which was $54 million. The additional $10 million that we've put into the system this year, for 2016-17, will allow LHINs to hire specialized health care staff to meet regional service needs for older adults with cognitive impairments in Ontario. It will also allow them to promote seamless care and coordination between service providers across sectors—so, moving into or out of long-term care—and enhanced services for individuals with challenging and complex behaviours.

All of the LHINs have developed locally appropriate implementation plans, and I'll also go further to say they're constantly refining those. As the populations change or as the needs of their providers change, they're constantly tweaking it.

The ministry's priority outcomes for BSO include:

—reducing resident transfers from long-term-care homes to emergency departments or hospitals or behavioural units in situations where the resident can be treated in a long-term-care setting. We do know that as residents move out of or into long-term-care homes, that's a particularly vulnerable point where behaviours can become activated, so the BSO is really targeted at trying to reduce that;

—delayed need for more intensive services, either in the community or the long-term-care setting, thereby reducing admissions to hospital or the risk of becoming ALC; and finally,

—targeting or reducing length of stay for persons in hospital, so that if the BSO supports are available in the home, or certainly with supports from an outreach team, then it will enable easier transition into long-term care.

The ministry maintains strong engagement with BSO stakeholders, including the BSO Provincial Coordinating Office and, as I mentioned before, the lead LHIN for BSO. Our BSO stakeholders include clinicians who are dealing with these residents on a daily basis. It is a very ground-up initiative, if you will, being built from the base up with people who are actually dealing with these residents on an ongoing basis.

BSO has been successful in establishing foundational health human resources capacity and other resources to support the care and safety of individuals.

One of the real successes of BSO is that care delivery has been enhanced through flexible models that can adapt to the needs in local areas; hence the important partnership that we have with the LHINs in rolling this out.

BSO is having real results for residents and families. In 2015-16, as an example, the BSO program received just over 33,000 referrals, with the majority being triaged to teams in long-term-care homes. As mentioned, the BSO service includes successfully supporting individuals as they move across the health care continuum. As reported by eight LHINs, in 2015-16, over 3,000 such transitions were supported by BSO teams, so we talk about transitioning across the continuum.

The third area I'll talk about in addition to legislative changes in Behavioural Supports Ontario is the behavioural support units program. I mentioned this quickly when I was answering MPP Munro's question, but I will elaborate a little bit more here.

Under the Long-Term Care Homes Act, in Ontario regulation 79/10, it does allow a LHIN to request that the ministry designate a specialized unit at a long-term-care home to meet the care needs of a specific population.

In requesting the designation for a specialized unit, the long-term-care home licensee and LHIN must provide the ministry with a thorough proposal, which will include the types of residents that would be eligible to be in that specialized unit, as well as any kind of funding considerations.

There are key objectives for the specialized units program, supporting the provision of specific care and services in long-term care, based on individual resident needs. It also supports residents' access to the right care at the right time in the right place. I think that was the point I was making to you earlier, MPP Munro. It provides flexibility to the LHINs to provide additional targeted funding to homes with these units and, in many cases, LHINs do top up the funding that the ministry provides through normal, routine funding.

To date, the ministry has designated a total of seven specialized units, two of which provide high-support specialized dialysis services to address complex residents living in long-term care. The other five are all specialized behavioural support units, and they include 19 beds at Sheridan Villa in the Mississauga Halton LHIN, 23 beds at the Baycrest Jewish Home for the Aged in the Toronto Central LHIN, 16 beds at Cummer Lodge in the Central LHIN, 32 beds at Hogarth Riverview Manor in the North West LHIN and, finally, 17 beds at Linhaven Home for

the Aged in the Hamilton Niagara Haldimand Brant LHIN.

The BSUs serve clients who are eligible for long-term care. That is one of the criteria to even get into a BSU. They must exhibit responsive behaviours associated with specific conditions, such as dementia, that cannot be managed in the general population of the long-term-care homes. All staff members who work in the BSU must receive training and education on the specific conditions of the target population and behaviour management.

Standard performance indicators or measures have been established for BSUs that the LHINs must report on, such as the number of referrals and admissions; the number of admissions by source, whether it's from a long-term-care home, from the community or hospital; clinical length of stay; the number of discharges by destination; and the number of readmissions. LHINs have reported positive evaluation findings and that these units are a valuable part of a local service continuum of care, hence our real interest in looking at this as a model of care that we want to expand.

The fourth area that I'll touch on very briefly is the High Intensity Needs Fund. The ministry, through the High Intensity Needs Fund program, provides funding to long-term-care homes for the cost of coverage for preferred accommodation and/or one-to-one staffing to support residents with severe behavioural response issues who may be at risk of harming other residents in the home. The ministry supports residents' needs through HINF funding on a case-by-case basis, so it's a claims-based program. Homes basically contact us in terms of requesting approval to go ahead with this, and we often will grant that.

Over the last three calendar years, investments in HINF claims for one-to-one staffing support and preferred accommodation have increased by 50% and 27% respectively. Hence, again, we can take that funding data and marry it with the inspection data and marry it with the clinical data to say, "Okay, we have a cohort here which needs some additional focus." This represents an increase in one-to-one staffing payments from about $8.7 million in 2013 to just over $13 million in 2015. For preferred accommodation, we went from just under $1 million to just over $1 million between the same period of time.

One of the other areas that we don't talk a lot about but which is integral to supporting all of this work are centres for learning, research and innovation, which are the CLRIs. There are three CLRIs that were established in Ontario. There's one at Bruyère in Ottawa, there's one at Schlegel in Waterloo, and the Baycrest CLRI in Toronto, which is a partnership of the Baycrest Centre for Geriatric Care and the Jewish Home for the Aged.

Since 2011-12, the CLRIs have provided evidence-based training and education to long-term-care homes and have brought together valuable partnerships between long-term-care homes and academic institutions that previously did not exist in this sector. Each CLRI has several initiatives under way that support the dissemination of education, research and innovation to staff providing care to residents with dementia and/or responsive behaviours in long-term-care homes. These initiatives are wide-ranging and can include research and dissemination of findings on potentially inappropriate prescribing in long-term care involving the validation of two deprescribing criteria. So there has been a lot of work done not only by CLRIs, but also by Health Quality Ontario in this area.

They've also looked at an extension of a longitudinal examination of triggers and prevention of responsive behaviours upon entry into long-term care. So what really are the trigger points that affect residents as they're transferring into long-term care? Again, that helps us to have really targeted solutions to address some of these issues.

The CLRIs also support long-term-care homes seeking to operate specialized units, including behavioural support units, and they've developed a best practices toolkit for long-term-care homes.

The Chair (Mr. Ernie Hardeman): Thank you very much.

Mr. Brian Pollard: Am I done? Okay.

The Chair (Mr. Ernie Hardeman): It looks like my attention span and your talking ended at exactly the same time. Thank you very much for your presentation.

That does complete the time for the presentation, so we will recess just for a moment while we, as we say, clear the gallery, and then we'll have an in-camera meeting to discuss working further with the reports.

Dr. Bob Bell: My colleagues and I thank the Chair and the committee for the questions and the conversation. Thank you.

The committee recessed at 1450 and continued in closed session at 1452.

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